



EXPRESS SCRIPTS®

## HOME DELIVERY PHARMACY ORDER FORM

## To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:  
Express Scripts Home Delivery Service  
P.O. Box 66785  
St. Louis MO 63166-6785

## To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
  - **Class II prescriptions cannot be faxed.**
  - Faxes will only be accepted from a doctor's office.

## PATIENT

Member ID: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Health Conditions: \_\_\_\_\_  
Over-the-Counter Medications: \_\_\_\_\_

## DOCTOR/PRESCRIBER

DEA: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

## PATIENT OPTIONS

- ☐ I want non-child resistant caps, when available.  
☐ I want a copy of my bottle label in large print on a separate sheet of paper.



2161

Rx	First Name	Last Name	Date: ____ / ____ / ____
Drug Name/Form/Strength	Qty	Directions for Use	Refills

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Doctor/Prescriber Signature – Substitution Permissible      Doctor/Prescriber Signature – Dispense as Written  
Stamped signatures cannot be accepted.

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